

S. No. 2  
M-5-42  
5-17-39  
I X3287

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

12093

LED APR 19 1943 318

Registration District No. ....

Primary Registration District No. ....

1003

Registrar's No. ....

3348

1. PLACE OF DEATH:

(a) County .....  
(b) City or town ST. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
BARNES HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 23 days  
(Specify whether  
In this community non-resident  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County .....  
(c) City or town Sigourney  
(If outside city or town limits, write "RURAL")  
(d) Street No. R.F.D.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8  
year 1943 hour 6 minute 0 P. M.  
21. I hereby certify that I attended the deceased from  
March 17th 1943, to April 8th 1943  
that I last saw him alive on 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death:  
Lung Abscess  
non-tubercular

Duration

7ms

Due to.....  
Due to.....  
Other conditions embolism  
(Include pregnancy within 3 months of death) 12 days

PHYSICIAN

Major findings: Lung abscess  
Of operations.....  
Of autopsy Lung abscess

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....  
(b) Date of occurrence.....  
(c) Where did injury occur?.....  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work..... (Specify type of place)  
(e) Means of injury.....

23. Signature G. F. Moor (M.D. or other)  
Address BARNES HOSPITAL Date signed.....

3. (a) PRINT FULL NAME Clarence Henry Engle

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Delphia Engle 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased September 25 1881  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>6</u>	<u>13</u>	hr. min.

9. Birthplace Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business.....

12. Name Jacob Engel Engle

13. Birthplace Pennsylvania  
(City, town, or county) (State or foreign country)

14. Maiden name Sussanah Millikin

15. Birthplace Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Irvin H. Reynolds  
(b) Address Sigourney, Iowa

17. (a) auto removal (b) Date thereof 4/9/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sigourney, Iowa

18. (a) Signature of funeral director Berger Memorial  
(b) Address 4715 McPherson

19. (a) APR 9 1943 (b) J. F. Brudeck  
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

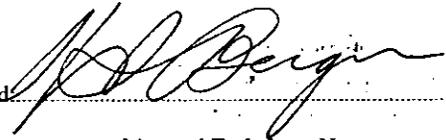
MOTHER FATHER

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed: 

Licensed Embalmer No..... 1597

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**